OSCAR Introduction Instruction for new users.

- 1. How do I log on?
 - a. In the office
 - b. Remotely
- 2. How do I access my schedule?
- 3. How do I get to my patient's chart?
- 4. How do I document a transaction?
 - a. SOAP note,
 - b. Order investigations,
 - c. Order labs,
 - d. Create referral letters,
 - e. Prescribe medications,
 - f. Billing/coding visits
- 5. How do I access my InBox (assigned transactions/tasks)?
 - a. Messaging (internal eMail)
 - b. Ticklers (scheduled messages)
- 6. How do I access historical information?

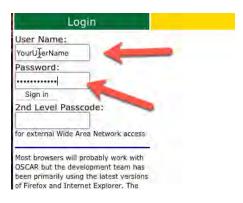
Click on question to take you to page in document

Disclaimer: Please be advised that the following materials were created by physician peer mentors and have not been endorsed or quality assured by OSCAR. In order to ensure they remain relevant with any technical upgrades, they will be reviewed by physicians on an annual basis. Please send any feedback or suggestions for improvement to RandRCommittee@doctorsofbc.ca.

How do I log on?

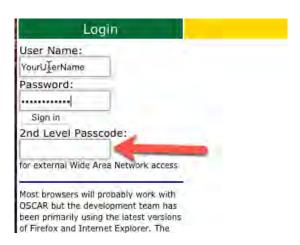
1. In the office

- a. You will be provided a user name (first name, e.g.) and a temporary password by the administrator. You may also need the 2nd Level Password, which will be provided. Use this to log in for the first time. You will be asked to create a new, unique password requires at least 8 characters, no spaces, at least one upper case letter and a special symbol. Don't forget this password or you will have to start over again with a temporary password. If you fail to log in successfully after multiple attempts, you will be locked out. You will need to contact the administrator to have your account unlocked.
- b. OSCAR is displayed in a web browser, preferably FireFox. If you are using a different browser, some features may not function. Chrome is an acceptable second choice. Safari and Internet Explorer are not recommended. Find FireFox here and download the ESR (extended support release) for your device. https://www.mozilla.org/en-us/firefox/organizations/
- c. You will be provided the IP address for local access to OSCAR, which will allow for server access when on the premises. If you are running a wireless device in the office, this will be the same as the Remote IP address.



2. Remotely

a. You will be provided an OSCAR IP address for remote access to the server. The 2nd Level Passcode is required to log in. Proceed as above.



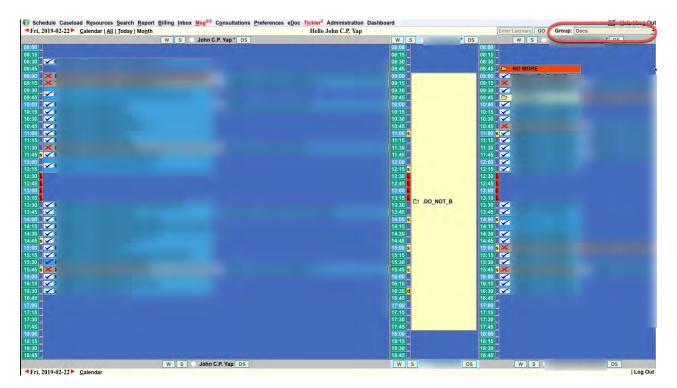
How do I log on?

HINTS:

- 1. Consider bookmarking the IP address for OSCAR for easier access.
- 2. Log out of OSCAR when you are finished with it.
- 3. Do not share or expose your passwords in any way. IT security is paramount.
- 4. Do not SAVE your passwords if the browser offers this option.
- 5. Do not leave your laptop or workstation unlocked when unattended. Lock it out with a secure password.
- 6. Do not use unsecured WiFi when working remotely. Starbucks and ShawOpen are NOT acceptable!
- 7. Viewed files are downloaded into your designated download folder. These files contain patient-sensitive, confidential information, and should be purged at suitable intervals.
- 8. If you fail to log on multiple times, **your account may be locked**. You will need to contact the office administrator to unlock your account. Your Oscar Service Provider can also help. Ensure you know who these people are and how they can be contacted.

How do I access my schedule?

1. Once you have successfully logged in, you will be In the SCHEDULE VIEW. If you are in a multi-doctor clinic, there may be multiple schedules displayed. Change the view by using the Group filter (top right).



2. Click on your name and the adjacent star to toggle the **zoom view** and **expand reason** views.

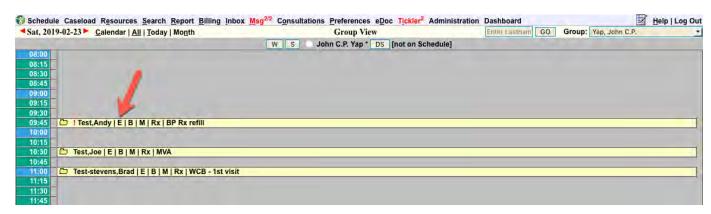


3. You will see notifications for InBox (labs, reports), Msg (internal eMail messages), and Ticklers (additional messages – usually managed by the MOAs). A red highlight indicates a new notice.



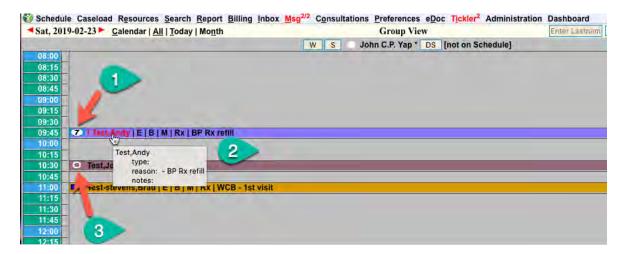
How do I get to my patient's chart?

1. From the SCHEDULE VIEW (aka day sheet), click on the "E" for the patient. E = encounter



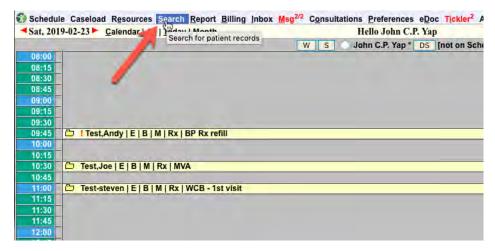
N.B. B = billing module. M = master record (demographics). Rx = prescription module. The colour and status icon may change to indicate what room the patient may be in, or whether the room is vacant.

- 2. Colour coding may vary from one clinic to another. See below.
 - (1) Patient is in room 7.
 - (2) Hover over the patients name for more details if Expand Reason is toggled off.
 - (3) This patient was a no-show.



How do I get to my patient's chart?

3. If the patient is NOT on the schedule, you will have to SEARCH for the patient by name.



4. Type in the last name (1) and first name (2), separated by comma; and then click on Search (3). **HINT:** the first 3 letters of the first and last names is generally all that is required. This only searches for ACTIVE patients. Deceased, moved, fired, and inactive patients are excluded from the default search. Click "ALL" if you wish to search the entire database.



A list of matching names will be displayed below this section. Choose the appropriate chart by clicking on the "E" for encounter page.

How do I document a transaction?

1. Writing a **SOAP note.**

From the schedule, click "E". Ensure the date on this entry matches the current date. If an earlier date is posted, you may have left an incomplete note previously. This old note must be completed and signed, otherwise you cannot proceed to write a new note, AND the other Oscar users cannot read your unsigned note. Save/sign/close the eCHART note before moving on to the next patient/chart. You return later to complete the note if desired, but ensure the chart is closed properly first.

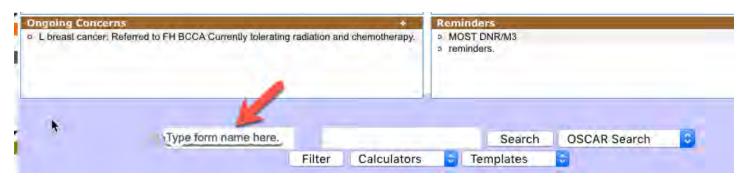


HINT: Ensure you are in the correct chart before you start and sign the note! Check the date!

- (1) Save force a save action. Usually, there is auto-save every 5 seconds, but this forces a save. The eCHART remains open.
- (2) Save, sign, and exit. Your note is now visible to all, but the visit is not billed.
- (3) Save, sign, exit, AND go to the billing.
- (4) Exit eCHART CAUTION your input has NOT been saved.

HINT: You may wish to do this if you have inadvertently started typing in the WRONG chart.

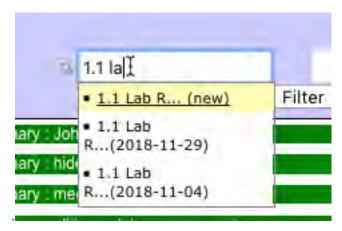
- 2. **Ordering tests** lab and imaging requisitions are eFORMS. They are accessed from within the eCHART to allow for proper autopopulation. You need to ask your clinic EMR lead for the NAMES of the common imaging, lab, and other requisitions (e.g. Special Authority forms, etc.).
 - a. Use the search box and call up a specific eFORM



Type the first few letters of the eFORM name, and matching selections will appear. Choose a "new" eFORM. Selections with dates are previously completed eFORMS that are saved.

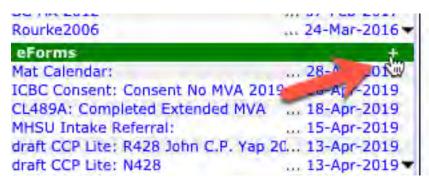
In GENERAL, do not reuse an existing eFORM to order new tests. Typing too much of the eFORM name sometimes creates an incomplete search. eFORMS with similar names cannot be found easily using this method.

One of the common eFORMS is the smart lab requisition – usually labelled 1.1 Lab requisition.



Click on the first entry (new) and the requisition will open.

b. Search eFORM index. The entire library of eFORMS can be accessed by clicking on the plus (+) sign in the green eFORMs banner. You can then use the browser search function (Ctrl-F or Cmd-F) to find the necessary form.



HINT: ask your clinic which are the commonly used forms and make a list of their names. Some of the names may not be intuitive.

Examples: 1.1 Lab Requisition, Imaging forms (many different versions, depending on Health Authority), Special Authority (and the various sub-types), PHQ9, GAD7, MMSE, MoCA (if available), ICBC CL 489 forms, Prenatal Genetic Screening, Complex Care Plan templates, COPD advisor, Brief Pain Inventory, doctors notes (sick notes), referral to allied professionals (physio, podiatry, RMT, etc.), MOST forms, DNR forms, etc.

- 3. Using various forms.
 - a. Rourke this is a "built-in" form, not an eFORM, and is accessed somewhat differently. In this example, a Rourke form was started Sep21/17. To add MORE information to this form, click directly on this link.



b. To open a new form, hover over the plus (+) sign and a drop-down menu of available forms will display. Move the mouse over the desired FORM and click on the link. You must always SAVE your work on these forms to close properly. Only the LATEST version will display in the eCHART view, but ALL versions will be saved in the background for audit purposes. The BC-WCB is a special FORM that acts as a "SOAP" note and the billing page!



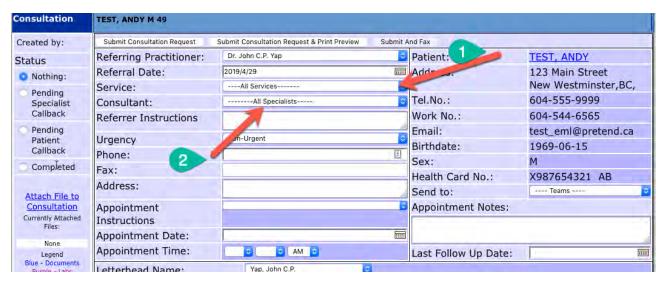
4. **Referral letters** (to consultants) – access this module by clicking the plus (+) link in the Consultations bar located near the bottom left margin of the eCHART.



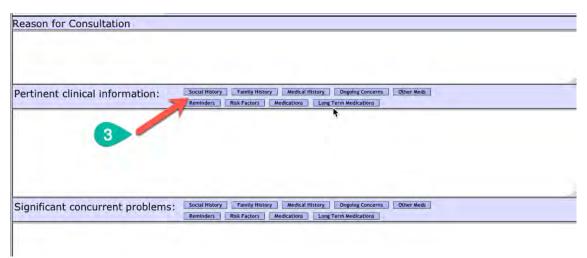
This opens a blank consultation template, which you will have to fill in with consultant's information. This information is preset by your clinic. If you do not find the consultant in your list, ask your office manager for assistance.

- (1) Choose the specialty
- (2) Choose the specialist.

HINT: once the drop-down menu opens, type the first letter of the specialty or specialist (last name) that you want, and the cursor will jump to the first item with that letter.



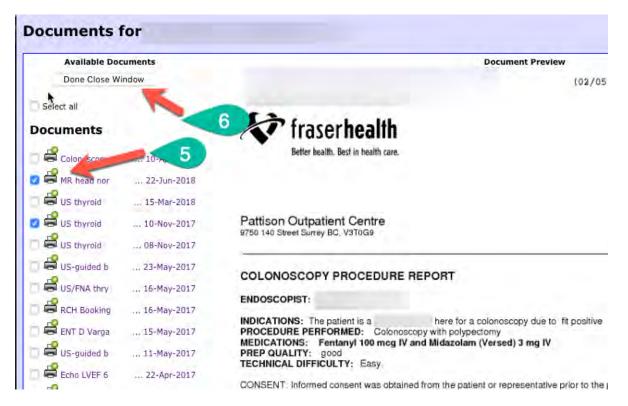
- (3) Add additional information that is available in the cumulative patient profile boxes by clicking on the relevant boxes. You can edit these items as needed (add new info, remove unnecessary details).
- N.B. Medications and allergies autopopulate.



(4) Add relevant reports and labs to consult letter by clicking the attach file hyperlink on the left margin.

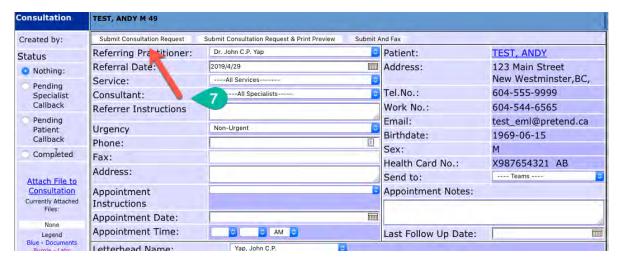


- (5) Check items you wish to add to the consultation letter. Click on the adjacent hyperlink for a preview of the item.
- (6) When done, click on the "Done Close Window" button. You can always return to the attach file area to add more or remove items. Just click Done/Close to complete the task.



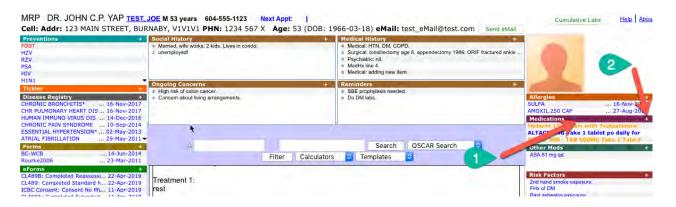
(7) Once completed, you must save (SUBMIT) the consultation letter, or all your efforts will be lost.

CAUTION: Do not be tempted to open an old consultation letter for review, while creating a new consult letter. This will result in the new draft letter getting replaced by the old letter – i.e. all your work will be lost!

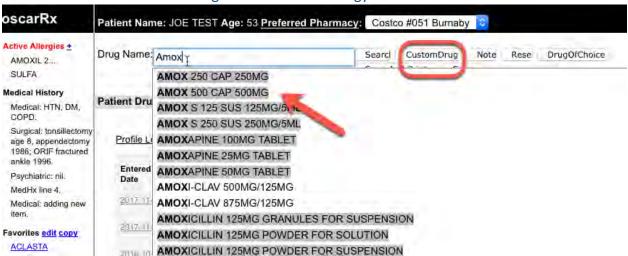


At this point, you should message the office staff to send the consultation letter. Do so within the patient's chart, so all relevant information is connected to the request.

5. **Prescribing Medications** – access the prescription module by clicking on the BAR labelled Medications (1), or the plus (+) sign (2). The first method brings up a "blank" template to start a new medication prescription. The second method brings up ALL the drugs labelled as long-term. In some situations, this may be desirable. The basics for prescribing are as follows:



- a. Prescription writing should follow certain syntax and grammar. This is to allow Oscar to internally calculate how long the medication is intended to be used short term, long-term, refills all captured with the correct grammar. In a paper world, a prescription written as "Amox 500 mg tid M:21" would be understood by the pharmacist. But Oscar prefers this: "Amox 500 mg po TID for 7 days" in the instruction line.
- #1. Start by searching for the desired medication. Type in the first few letters of the drug, and even the dosage, which will filter the drop-down list. It is preferable to choose the drug which has NO GENERIC PREFIX to avoid clarification calls from the pharmacy. In the example below, Amox 500 mg is requested. Note the allergies. Avoid the use of CUSTOM DRUG as this will disable drug interaction and allergy checks.



#2. This patient has an allergy to Amoxil, which will be highlighted once the Rx is written in full. The warning may be bypassed, if appropriate. If the tab key is used to navigate from the instruction line, the quantity will auto-calculate. If there are refills noted, the Long-Term Med button is auto-checked. The red asterisk at the end of the field opens a pop-up showing previous instructions for that same drug. This may offer some clues as to dosing. Click on a desired line if the instructions suit your needs.

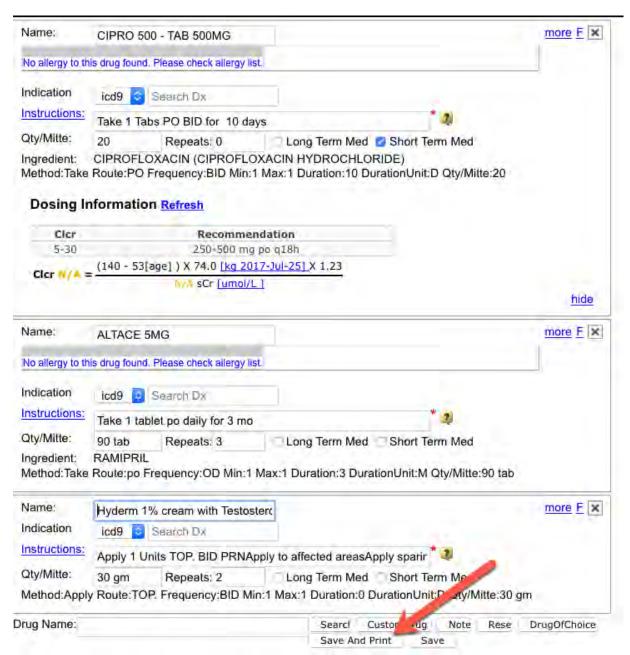


Add another medication, if desired, in the Drug Name Box at the bottom, and repeat steps #1 and #2.

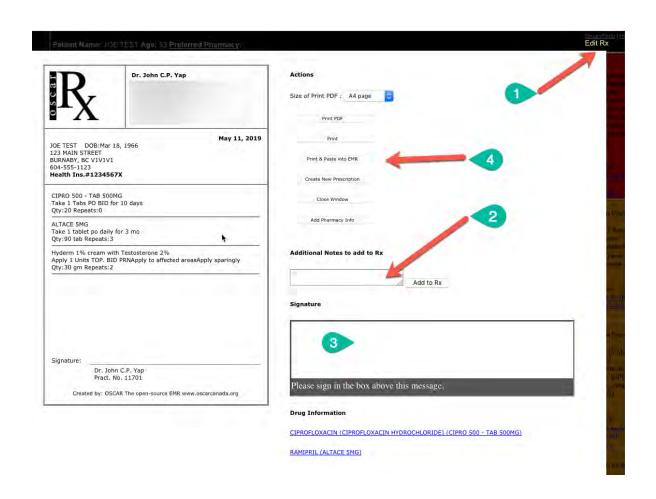
#3. Refill an existing medication by highlighting the relevant checkbox(es), and clicking ReRx on one of the lines. The entire list will by loaded for review and edit. You may change instructions, quantity, etc., but you CANNOT change the drug name or dose. The drug name is associated with a specific DIN (drug identification number) and this is unique, allowing for allergy and drug interaction checks. Changing this will make the drug name a "custom drug".



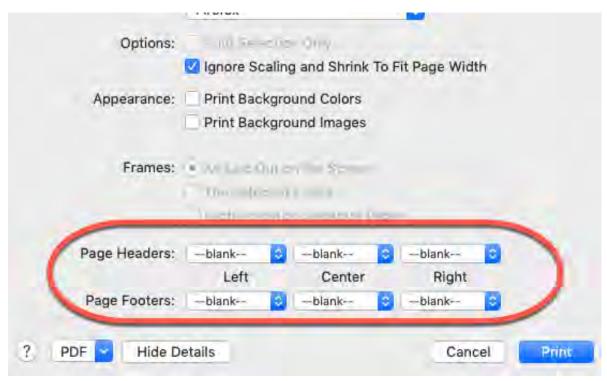
When you have completed the list of medications for prescription, click "Save and Print" to see the Preview.



#4. The Preview allows you to return to the previous page - Edit Rx (1) - if you need to add more, change instructions, or remove an item. You can also add comments in the "Additional Notes" section (2), and this will be added to the bottom of the Rx. Examples may be: blister pack, for early refill, faxed to pharmacy, etc. You may even add a signature with your mouse in the Signature Section (3) – this needs to be saved to embed in the Rx. Usually, the Prescription is printed to paper for a "wet signature". When satisfied with the Preview, click "Print & Paste into EMR" (4) to add the Rx list to the encounter note and Print to your local printer.



N.B. Ensure that headers and footers are set to blank on our device. Ask your office manager for assistance to do this.



[11-May-2019 .: Tel-Progress Note]

CIPRO 500 - TAB 500MG Take 1 Tabs PO BID for 10 days Qty;20 Repeats;0

ALTACE 5MG Take 1 tablet po daily for 3 mo Qty;90 tab Repeats;3

Hyderm 1% cream with Testosterone 2% Apply 1 Units TOP, BID PRNApply to affected areasApply sparingly Qty;30 gm Repeats;2

You may reposition the list of medications anywhere in your SOAP note. Just copy/cut/paste as needed.

Additional features to ask your Office Manager or colleagues to demonstrate: use of custom drugs, favourites, activating long-term status, deactivating long-term status.

Key Points: Use the proper syntax when writing a prescription. Ensure a duration of use is stated. Use Long-Term or Short-Term when appropriate. Avoid use of Custom Drugs if possible. Use the prescription module to document triplicate prescriptions and even samples!

- 6. **Allergy Module** noting allergies properly is critical. Use same strategy to search for the specific drug, or drug class as for writing a Rx. Avoid use of Custom Allergy it may seem faster, but there is no internal auto-checking with custom allergies. Save Custom Allergy for special situations such as allergy to shellfish, etc.
 - #1. Click on the Allergy BAR, or plus (+) sign. Existing allergies are listed, and may be inactivated or modified (1) only available in Oscar15. Some preset allergies are available as quick-pick buttons (2). Or Search (4) for the desired drug, and check off the appropriate level of search (3) usually drug classes, generic and brand names are desirable. It is preferable to choose a drug class (e.g. Penicillin) rather than a specific drug within that class (e.g. Amox). Use Custom Allergy as a last resort.
 - N.B. NKDA as a "custom allergy" is allowed.





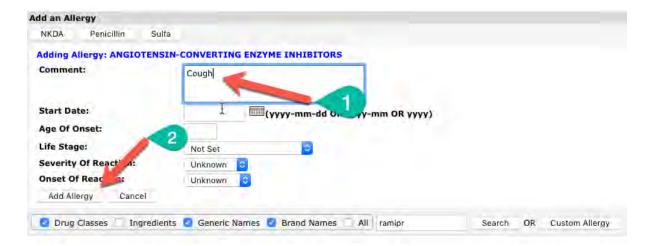
#2. Search for Ramipril: type in part of name (1), choose the categories, and click "Search" (2).



A drop-down list should appear. Choosing the class of drug is preferable – i.e. ACEI (2).

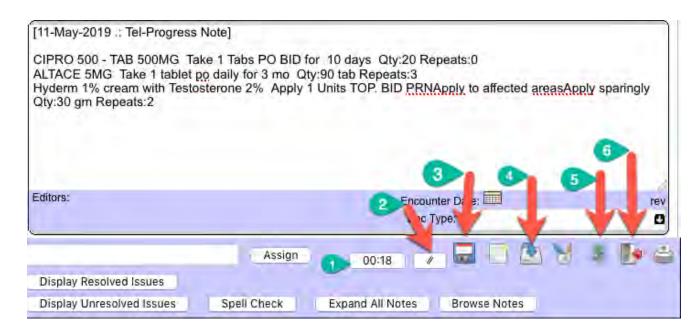


Click on the appropriate link, then add comment to describe the reaction (1), and other details if desired. Click "Add Allergy" (2) to save the information.



Key Points: Avoid the use of Custom Drugs or Custom Allergies.

7. **Billing** – most physicians will bill themselves, after completing the note. Some private bills can be generated by the Office staff. Access the Billing Module using the Save and Bill icon in the encounter note.



- (1) Timer click to paste start/stop time into the bottom of your current encounter note. N.B. Timer restarts at current time if you leave/close note and return, so activate the start time early by clicking this button when needed.
- (2) Timer pause/restart.
- (3) Force save note will be saved, but not signed. Usually not needed, as auto-save is activated every 5 seconds, or so.
- (4) Save and exit forces a full save, signature and time stamp added, and encounter note is closed. To further edit this note, you have to return to encounter page and click "edit" link in the top right corner of this note.
- (5) Save Sign & Bill once the note is complete, you can save and go directly to the billing page. Once you click this icon, the chart is closed and cannot be viewed.

HINT: make sure you remember what the diagnosis is – for the billing page!

(6) Exit – use if you DO NOT WISH TO SAVE ANY OF YOUR CHANGES, and wish to close the note. Very useful if you are typing in the wrong chart! This is the proper way to leave a note without saving any foot print of your actions – if you are typing in the wrong chart.

HINT: if the note belongs in a DIFFERENT CHART – select and copy the work to PASTE into the correct chart! Do this before you EXIT the wrong chart.

On clicking Save Sign & Bill – the billing page opens: Patient TEST, JOE Age 53 Invoice List Patient Status Billing Form Billing Physician Billing Type Clarification Code Service Location Yap, John C.P. Bill MSP VANCOUVER. Al Practitioner's Office - In Community GP general practice Service to dateAfter Hours Start (HHMM 24hr): End (HHMM 24hr): Time Call Sub Code Service Date **Payment Method** 2019-05-11 0 0 O - Normal FIECTRONIC acility Office Visits \$Fee Other SFee SFee IN OFFICE ASSESSMENT IN ASSOC VISIT IN OFFICE (AGE 50-59) 34.62 15300 13070 16.36 ANTICOAGULATION THERAPY BY WITH A WSBC SERVICE 6.95 COMPLETE EXAMINATION IN OFFICE IN OFFICE ASSESSMENT IN ASSOC 15301 76.83 ADVICE ABOUT A PATIENT IN 13075 16.36 (AGE 50-59) WITH AN ICBC SERVICE 15.72 INDIVIDUAL COUNSELLING IN OFFICE ALLIED CARE PROVIDER PRACTICE 15320 60.23 14029 0.00 INSERTION INTRAUTERINE (AGE 50-59) HOME VISIT(SERVICE RENDERED CONTRACEPTIVE DEVICE (IUD) 115,15 00103 14043 GP MENTAL HEALTH PLANNING FEE 100.00 BETWEEN 0800-2300HRS) ROUTINE PELVIC EXAM INCLUDING PAP 31.46 GP ANNUAL CHRONIC CARE 14050 125,00 Referral Type Referral Doctor INCENTIVE-(DIABETES MELLITU 14066 PERSONAL HEALTH RISK ASSESSMENT 50.00 GP ANNUAL CHRONIC CARE Refer To 14051 125.00 GP ATTACHMENT PARTICIPATION INCENTIVE-HEART FAILURE 14070 0.00 GP ANNUAL CHRONIC CARE ANNUAL COMPLEX CARE MANAGEMENT 14052 50.00 14033 315.00 INCENTIVE-HYPERTENSION GP ANNUAL CHRONIC CARE INCENTIVE GP ATTACHMENT COMPLEX CARE 14053 125.00 14075 315.00 Recent Referral Dators Referral Doctor on Master COMMUNITY BASED GP: HOSPITAL GP ATTACHMENT TELEPHONE 13228 29.85 20.00 14076 none none COMMUNITY BASED GP,1ST FAC VISIT SP ATTACHMENT PATIENT 13338 38.10 40.00 CONFERENCE FEE COM BASED GP,1ST HOSP VISIT OF GP EMAIL/TEXT/TELEPHONE MEDICAL 29.85 13339 DAY BONUS, EXTRA ADVICE RELAY FEE VISIT NURSING HOME ONE OR 36.13 00114 31.46 MULTIPLE PATIENTS 00190 REMOVAL OF WARTS ETC NURSING HOME VISIT - 1 PATIENT EXCISION TUMOR OF SKIN/SCAR UP TO 115.15 13620 66.02 WHEN SPECIALLY CALL LTC FACILITY VISIT-FIRST VISIT OF PREGNANCY TEST, IMMUNOLOGIC, 13334 34.06 15120 11.59 DAY BONUS, EXTRA URINE ABSCESS - SUPERFICIAL 44.26 13605 URINALYSIS - SCREENING 2.17 MINOR LACERATION/FOREIGN BODY 13611 66.02 11.31 00034 INJECTION SUBCLITANEOUS GP POINT OF CARE (POC) TESTING 15039 12.75 00044 MINI TRAY FEE 5.19 ESTING FOR 00090 MATOR TRAY 31.21 15040 12.75 INJECTION, INTRAMUSCULAR 11.31 00039 23.60 INJECTION, INTRA-ARTICULAR - ALL TREATMENT ON NO CHARGE REFE 0.00 Other service/procedure/premium codes L-4m .5 460 51H .5 286 58W .5 848.5510

- (7) Choose the visit fee usually preset for appropriate age-based adjustment.
- (8) Add referral physician name if making referral.

HINT: type part of last name and first name, separated by comma to generate dropdown list. Most of the time, the referral type is "Refer To". An error may occur if this is not selected.

10

Short Claim Note

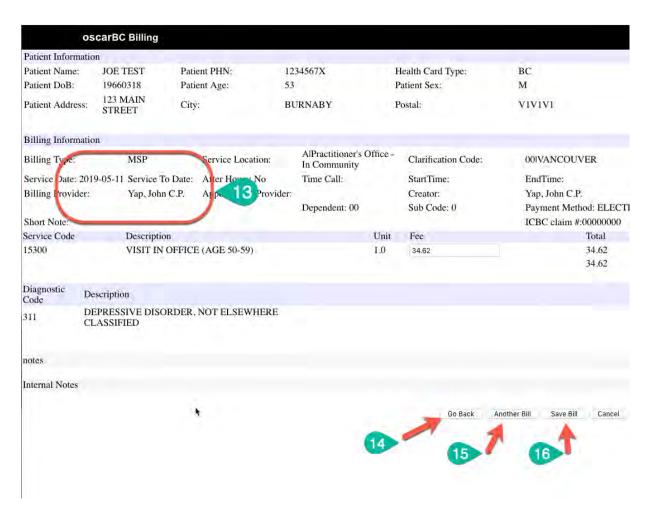
No Correspondence

Billing Notes (Notes are for Internal use and will not be sent to MSP)

Ignore

Continue

- (9) Fee code either generated by quick pick in (7), or added manually.
- **HINT:** you can search with a key word (start typing part of word and hit enter).
- (10) Diagnostic code enter appropriate ICD-9 code, or search using key word (start typing part of word and hit enter).
- (11) Choose a previously used diagnostic code from the list.
- **HINT:** hover over the code to see the text describing the code.
- (12) Click "Continue" to see billing preview page.



- (13) Ensure the proper Billing Provider is named, and the date is correct. Default date is TODAY.
- (14) If there is an error, "Go Back" returns you to the previous page to make changes.
- (15) Click to save this claim, and create **ANOTHER** bill for the SAME patient. Example bill an office visit for WSBC, and then bill a second item for MSP service on the same day.
- (16) Save Bill click to save and close the billing module.

Cancel and leave if you do not wish to bill at this time.

8. **Messages, InBox, Ticklers:** this is how Oscar notifies the user about tasks, messages, and reports.



- (1) InBox items include labs and scanned documents. This indicates there are 9 items pending for review.
- (2) Msg items are internal eMail type messages between Oscar user(s) who have Oscar accounts. You can use this to send a message to YOURSELF, to complete a task.
- (3) Ticklers are TIMED/SCHEDULED messages between Oscar users which can be set for a future date, or for TODAY. They are usually reminders scheduled for a future date e.g. next Pap, etc.
- a. **InBox** this is where you will find new reports for your review and acknowledgement. These includes labs, imaging reports, consultations, insurance request, etc.



#1. There is one InBox item to be processed Click on the InBox link to show the List View.



#2. **List** mode shows every item in a separate line. The left margin is sorted alphabetically by last name. Click here to see JUST the items associated with that patient. Or click on the main screen to see each item one at a time. Click on the Preview button to switch to Preview mode.



#3. **Preview** mode has the advantage of showing the document in the main window. You can scroll down to read additional pages, etc. You can scroll on the larger window to go to the next patient report, also in Preview Mode. The best way to experience Preview Mode is to click on the left side margin – any order is fine – to display the report, read, review, and then act on and acknowledge the report.

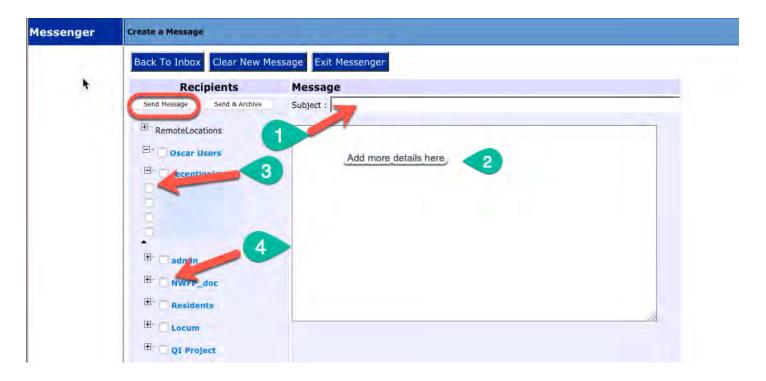


- (1) **Acknowledge** to note you have reviewed the report and file it in chart. This should be done last, as it will close the report after. You may be asked to add a comment to this report on filing. This can be left blank.
- (2) **Msg** send message related to the report. **HINT:** you can remind yourself to follow up in some way.
- (3) **Tickler** set up a scheduled memo related to this report.
- (4) Enter a **label** to better describe the report. After you type in label, click on the blue "label" button to save it. **HINT:** use abbreviations, and develop a logical format. There is limited space to display this label in the eCHART. You can change the label as often as you wish.

HINT: if the result needs to be highlighted for another physician who does not appear in the CC chain (top right), click on the **Forward** button, and a pop-up will allow you to send the result to another physician **within** the clinic. You may wish to also **Msg** the other physician to note your concern.

b. **Msg** – this is similar to internal eMAIL, which can be sent to single or multiple recipients, including yourself as a reminder. A Msg can be non-linked to a patient, such as an announcement to the office of a meeting, e.g. Creating a Msg with a patient's chart will link that message to that patient, so it is easier for the recipient to open the chart. See all messages linked to the patient by clicking the Messenger Bar (1). Create a Msg by clicking the plus (+) sign (2) in the Messenger Bar.





- (1) Every message must have a **subject**. This line is displayed in the eCHART. Keep the subject discrete. Example see lab if you want a colleague to review an important lab result related to that patient.
- (2) The body of the message can be more detailed, or can be a blank **space**. It cannot be totally blank, however.

- (3) Choose a specific recipient, or group of recipients. See the individuals in a group by clicking on the plus (+) sign.
- (4) Choose the entire group if desired e.g. all doctors, all MOAs. Each clinic will define their own groups.

HINT: if your name does not appear here, you need to speak to the Office Manager or IT support.

When you have completed the Msg, click "Send Message". The "Send & Archive" button is used when you **RESPOND** to a message that is sent to you.

c. **Ticklers** are generally created by the MOAs to recall patients as per screening protocol, or when the MD requests a **future** follow-up appointment. They are also used as reminders for appointments, etc. They are ALWAYS linked to a patient, and must be created from within the patient's eCHART or master demographic page.



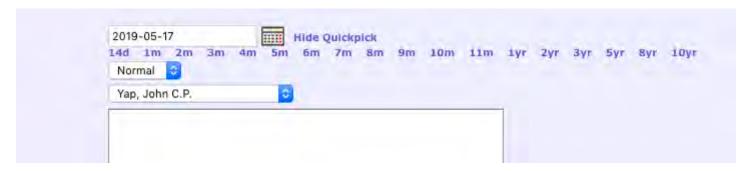




Default date is today (1). This can be changed with direct entry, or by clicking Show Quickpick (4). The default recipient of the Tickler is the current user (2). Click on this box to reveal other recipients.

HINT: click on the first letter of the last name to jump directly to that section of the list. Example – clicking M will bring up MOA, etc.

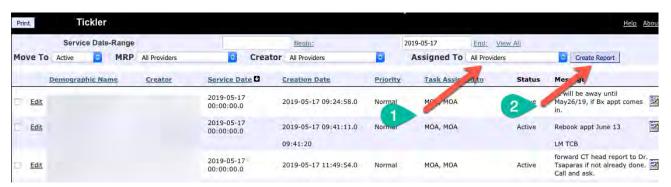
Add relevant details in the subject box (3). Click on Submit and EXIT (5) to send.



Click on the appropriate Quickpick link to fast forward to that date. Click on the calendar icon to choose a specific date from current month. N.B. This is less efficient in most cases.



Any Ticklers currently directed to you will be announced from the schedule page. There are 2 Ticklers pending action. As well as 9 InBox tiems, and 3 messages, in the example above.



Click on the Tickler link on the menu bar, and the Tickler module appears. The default view shows Ticklers assigned to ALL PROVIDERS. Filter down to Ticklers for you by clicking on the Assigned To drop-down menu (1), and the clinic list will appear.

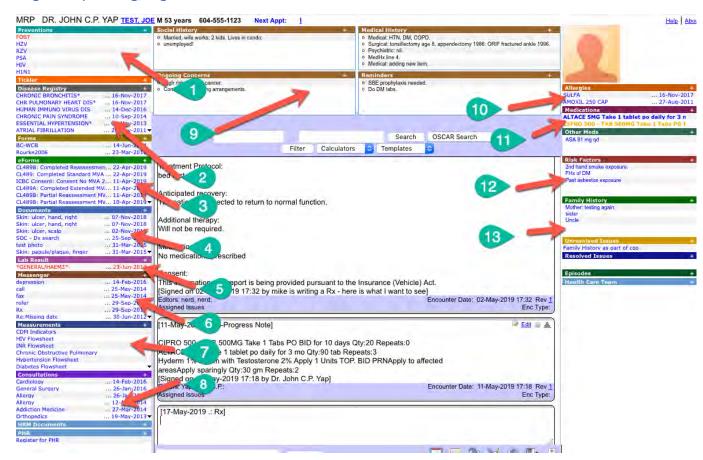
HINT: click on the first letter of your last name to jump to your section.

Highlight your name, and click Create Report (2) to see only those Ticklers assigned to you.

NOTE: the ticklers set for today (current) are a the top. Older ticklers (potentially overdue) are at the bottom. Future ticklers are not displayed, unless the END DATE is changed for that future date.

How do I access historical information?

Almost all relevant historical information is accessible from the eCHART page. This requires some degree of planning, organization and maintainence.



Vaccines and various health-related screening found in the Preventions module (1). Major conditions are noted in the Disease Registry (2). Some of the disease conditions will trigger relevant chronic disease flow sheets (e.g. HTN, DM, etc.). The library of used eFORMS found here (3). Some of the eFORMS are clinical calculators (MMSE, PHQ9, etc.) and the scores will usually be displayed in this index. Scanned documents will be listed here (4), in order of observed date. If the titles are properly labelled, you may not need to open the document to read the entire contents. Click on the hyperlink to see the full document. Click on the down arrow to open the index fully and show all the documents as titles. Click on the document BAR, and you will open the Document Library – which provides even more details. Most lab results will be displayed here (5). These are digital labs, not scanned from paper. The titles are not as helpful, unfortunately. Hover over the plus (+) sign of Lab Results to show labs in a different Display mode. Row Display is especially useful. Clicking on a lab result will generally create a report of ALL values for that specific item. This is useful to assess trends. The list of messages appears here (6), in chronological order, newest at the top. The measurements module is a very important one (7). Discrete measurements (labs, vital signs, MMSE score, etc.) are either manually added here, or automatically added by Oscar. Hopefully, your clinic has relevant measurement groups set up for you.

HINT: It is PREFERABLE to input vital signs in the measurement area, rather than typing them into the encounter note. Once the VS are saved in measurements, the get pasted into the encounter note for you anyway!

The list of consultation referral letters is found here (8). The cumulative patient profile (CPP) encompasses the 4 boxes here (9), and the additional boxes in the right margin (12) and (13). If there are important clinical details relevant for optimal care of the patient, they should be highlighted here. Add a new line (bullet) by clicking on the plus (+) sign. Add to an existing line simply by clicking on the line to open an edit window. Don't forget to SAVE the changes before closing, otherwise your work is not recorded.

Allergies (10) and Medication list (11) are found on the right margin. A down arrow in the bottom corner indicates more entries that are hidden. Click the arrow to show the hidden entries.

HINT: if a title seems incomplete, make the entire window bigger by dragging the browser size larger in the horizontal plane. Hovering your mouse over the title will enable a pop-up showing more of the title.

Oscar should be relatively intuitive to use, with most of the necessary information accessible from the eCHART view. Take care to ensure you are in the correct chart. Exit from the chart with the proper icon if not. Ensure you sign and save your note when done. If incomplete, or additional details are required, you can always re-open the old note and EDIT (top right corner of the note field) the note further. Each time you sign and save the note, an additional signature and time stamp is added. Pay special attention to how you write prescriptions – ensure a duration is specified so Oscar will know whether the medication is short, mid, or long-term. Ensure each eFORM or FORM you create is submitted (saved) or all your work will be lost, and there will be an incomplete audit trail. Please use the measurement function to record relevant discrete data (BP, Ht, Wt, etc).